DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: SPA #03-31

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 2, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 0
b. FFY 2005 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A
Pages 4, 7 & 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A
Pages 4, 7 & 16

10. SUBJECT OF AMENDMENT:
Annual DRG Update

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:
Janet Schalansky is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//Janet Schalansky – signature//

13. TYPED NAME:
Janet Schalansky

14. TITLE:
Secretary of Social & Rehabilitation Services

15. DATE SUBMITTED:
December 23, 2003

16. RETURN TO:
Janet Schalansky, Secretary
Social & Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 651S
Topeka, KS 66612-2210

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DEC 23 2003

18. DATE APPROVED: June 28, 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN - 2 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Dennis G. Smith

21. TYPED NAME: DENNIS G. Smith

22. TITLE: DIRECTOR, CMSO

23. REMARKS:

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

1.0000 continued

y. "Readmission" means the subsequent admission of a recipient as an inpatient into a hospital within 30 days of discharge as an inpatient from the same or another hospital participating in the DRG reimbursement system.

z. "Recalibration" means the adjustment of all DRG weights to reflect changes in relative resource use associated with all existing DRG categories and/or the creation or elimination of DRG categories.

aa. "Standard diagnosis related group (DRG) amount" means the amount computed by multiplying the group reimbursement rate for the general hospital by the diagnosis related group weight.

bb. State-operated hospital= means an establishment operated by the State of Kansas with an organized medical staff of physicians, with permanent facilities that include inpatient beds, with medical services, including physician services and continuous registered professional nursing services for not less than 24 hours of every day, and which provides diagnosis and treatment for nonrelated patients.

cc. "Stay as an inpatient in a general hospital" means the period of time spent in a general hospital from admission to discharge.

dd. "Transfer" means the movement of an individual receiving hospital inpatient services from one hospital to another hospital for additional related inpatient care after admission to the previous hospital or hospitals.

ee. "Transferring hospital" means the hospital which transfers a recipient to another hospital. There may be more than one transferring hospital for the same recipient until discharge.

2.0000 Reimbursement for Inpatient General Hospital Services According to Diagnosis Related Groups (DRGs)

2.1000 Hospital Participation Effective Date

Effective with services provided on or after January 2, 2004, general hospitals will be paid in accordance with the Kansas Medicaid/MediKan Diagnosis Related Groups (DRG) Reimbursement System described in 2.0000 and 3.0000. This does not include state-operated hospitals. State-operated hospitals are discussed in 4.0000.

2.2000 Billing Requirements

This section describes variations in how billings should be made by hospitals.

2.2100 General Billing

Under the DRG Reimbursement System a hospital may bill only upon discharge of the recipient except as noted in subsections 2.2200 and 2.2300.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

385 Short stay neonates died or transferred (2 day maximum)
386 through 388 No longer used
389 Birth weight > 2000 grams, full term with major problems
390 Birth weight > 2000 grams, full term with other problems
391 Birth weight > 2000 grams, premature or full term, without complicating diagnoses
801 Birth weight < 1000 grams
802 Birth weight 1000 - 1499 grams
803 Birth weight 1500 - 2000 grams
804 Birth weight > 2000 grams, w/ respiratory distress syndrome
805 Birth weight > 2000 grams, premature w/ major problem

After the DRG number reassignments, all these claims became part of the total data base used for the DRG Reimbursement System.

Subsections 2.4100 through 2.4700 provide a discussion of the development of all the system components for use effective January 2, 2004. The discussion flows in the order of the steps performed for the computations involved. For example, the establishment of the data base (Subsection 2.4100) was necessary before cost determination (Subsection 2.4200), outlier claims had to be identified (Subsection 2.4300) prior to separating them out from the data base (Subsection 2.4410).

2.4100 Data Base

For developing the DRG relative weights, group payment rates, and other system components for use effective January 2, 2004, the Department used as data base the Medicaid/MediKan paid claims for services the eighteen month period ending in April, 2003. Certain claims were excluded from the data base while some others were modified before including in the data base as listed below.

2.4110 Claims Excluded from the Data Base

- crossover claims (Medicare paid by Medicaid).
- swing bed claims.
- claims paid from out-of-state hospitals.
- claims from transferring hospitals (in case of transfers, only the claims from the final discharging hospitals were included in the data base), except for DRG's 385 and 456.
- adjusted claims (in cases where a hospital resubmitted a claim with corrections, the original claim was excluded from the data base. Only the final paid claim was included).
- interim claims which could not be matched together.

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care
2.4430 continued

Analysis

The relative weight of .6881 in this example means that this DRG is less expensive to treat than the average DRG (with a weight of 1.0000). In other words, it indicates this DRG costs 31.19% less in relation to average DRGs.

2.4440 Modification of Relative Weights for Low-Volume DRGs

If very few paid claims are available for a DRG, any one claim can have a significant effect on that DRG's relative weight, day outlier limit, cost outlier limit, and daily rate. A statistical methodology was used to determine the minimum sample size required to set a stable weight for each DRG, given the observed sample standard deviation. For DRG's lacking sufficient volume in the Kansas Medicaid/Medikan claims data base, the DRG weight was derived using an external data base, with preference given to DRG weights derived from populations expected to be similar to the Kansas Medicaid/Medikan population. Sources used were an average of four states all payer data from 1997 from Kansas, Colorado, Iowa, and Wisconsin, and HCFA Medicare weights where other alternatives were not sufficient.

Outlier thresholds and average length of stay statistics for DRG's with externally derived weights were set using the appropriate statistics from the same external source. For DRG's whose weights were derived from Federal Medicare weights, in which case published cost outlier thresholds are based on a substantially different formula than is used by Kansas Medicaid, a least-squares regression equation was used to estimate the outlier threshold, based on the DRG weight.

2.4450 Modification of Relative Weights for Selected DRG Pairs

In cases of DRG "pairs" - one DRG with complications and co-morbidity (CC's) and the other DRG without CC's - if the DRG without CC's was weighted higher than the DRG with CC's, the relative weights of both DRG's were replaced with the weighted average of the two relative weights.

2.4500 Group Payment Rates

The Kansas Department of Social and Rehabilitation Services determined group payment rates for the three general hospital groups discussed in section 2.3000. The group payment rates are used in conjunction with DRG relative weights and other components developed for the Kansas DRG reimbursement system to determine payment. An adjustment factor of –7.4% was applied to the group payment rates effective January 2, 2004 as a budget neutrality factor.